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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** August 18, 2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar discogram at L3-4 and a computed tomography (CT) scan to follow (62290, 72295, 72131).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

M.D., Board Certified in Orthopedic Surgery.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒**Upheld** **(Agree)**

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The requested lumbar discogram at L3-4 and a computed tomography (CT) scan to follow (62290, 72295, 72131) is not medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx year-old xx who reported a work-related injury on xx/xx/xx. The documentation dated xxx revealed the patient had a two-level instrumented fusion in xxxx and a hardware removal in xxxx. Over the prior xxxx, the patient had a significant increase of low back pain that radiated into the bilateral buttocks, more so on the right than the left. Approximately one xxx of the xxxx, the patient was reported to be bedridden. The patient had no loss of bowel or bladder control. The patient had no recent imaging. The examination revealed significant

tenderness to palpation in the lumbar paraspinal musculature bilaterally. There was tenderness in the bilateral sciatic notches. A Faber's maneuver was negative bilaterally. The straight leg raise reproduced low back pain and buttock pain. His strength was intact in the right lower extremity and intact in the left lower extremity with the exception of some weakness with left plantarflexion. Sensation was intact in the bilateral lower extremities. Radiographs revealed the patient had an apparent solid arthrodesis from L5-S1 with interbody cages at L4-5 and L5-S1. The patient experienced significant increased debilitating pain over the prior year, and it was getting worse rather than better. Magnetic resonance imaging (MRI) of the lumbar spine with gadolinium was recommended to evaluate the lumbar pain and radiculopathy. The patient underwent an MRI of the lumbar spine on xxxx, which revealed status post previous anterior fusion at L4-5 and L5-S1. There was no recurrent stenosis detected. There was no abnormal enhancement seen. The patient appeared to have a previous left hemilaminotomy at L4-5 level. A complete laminectomy was not detected. The foramina appeared to be adequate. There was mild facet hypertrophy at L3-4 level. There was a small disc bulge without focal stenosis. The foramina appeared to be adequate. The other disc space levels were normal and the conus signal intensity was normal. An office visit dated xxxx indicated the patient continued to struggle with low back pain and bilateral lower extremity pain. The patient had no loss of bowel or bladder control. His current medications included Norco 10/325 and Fentanyl 25 mcg. The physical examination revealed tenderness in the lumbar paraspinal musculature. The straight leg raise was negative in the bilateral lower extremities. Sensation and strength were intact to the bilateral lower extremities. The provider indicated that the most likely area of pain was opined to be at the L3-4 level and the patient was most likely starting to experience adjacent segment problems. The provider recommended a discogram of L2-3 and L3-4. On xxxx an office visit noted he was evaluated for back and leg pain. The patient indicated his pain remained unchanged as compared to the prior visit in January. The patient had difficulty with chronic axial back pain radiating primarily down his right leg. The impression included the patient had adjacent segment disease with right foraminal narrowing and facet hypertrophy at L3-4. The provider recommended a discogram of the L3-4 level as the patient had moderate bulge.

The URA denial letter dated xxxxx indicates that that there is an absence of established criteria for medical necessity within the associated medical file.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

According to Official Disability Guidelines (ODG) myelography and computed tomography (CT) myelography are not recommended except for selected indications when MR imaging cannot be performed, or in addition to MRI. Myelography and CT myelography are adequate if an MRI is unavailable or contraindicated or is inconclusive. The criteria include demonstration of the site of cerebrospinal fluid leak and surgical planning especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising in a given case, and if it is, can help in planning surgery. There should be poor correlation of physical findings with MRI studies. In this case, the documentation indicated the requested services are for surgical planning. However, the patient had MRI findings and there was a lack of documentation of poor correlation of physical findings with MRI studies. The provider indicated that the area of pain was most likely at L3-L4 and that the patient is most likely going to start experiencing adjacent

problems and should undergo testing to establish whether he did or did not have those problems. This does not support the request for a lumbar discogram and a CT scan to follow. As such, the request for a lumbar discogram at L3-4 and a CT scan to follow (62290, 72295, 72131) is not medically necessary for the treatment of the patient's medical condition.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☐ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**